ADJUSTMENT REQUEST (525-109)

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Division of Program Support
PO Box 45560
Olympia, WA 98504-5560

REQUIRED FIELDS*

USE BLUE OR BLACK INK ONLY

1. CLAIM NUMBER TO BE ADJUSTED*	2. PROVIDER NUMBER*	3. PATIENT PIC NUMBER FROM RA*

4. DATE(S) OF SERVICE	5. DATE OF REQUEST	6. PATIENT'S NAME (LAST, FIRST, MI)
FROM: TO:		

7. ITEMS TO BE CORRECTED

More than one item per claim can be addressed, however no more than one claim per adjustment request

A. LINE/DATE	B. INFORMATION FROM RA/ORIGINAL CLAIM	C. CORRECTED INFORMATION

8. /*OTHER REMARKS/AWARD LETTERS/JUSTIFICATION (ATTACH COPIES/REPORTS):

9. THIRD PARTY INSURANCE INFORMATION - ATTACH INSURANCE EOB

NAME OF INSURANCE COMPANY	AMOUNT PAID BY INSURANCE	BALANCE OWING

PROVIDER TELEPHONE NUMBER _____

10. PROVIDER NAME AND ADDRESS

MAIL TO:

DIVISION OF PROGRAM SUPPORT
PO BOX 45560
OLYMPIA, WA 98504-5560